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CHAPTER THIRTY-SEVEN

MANAGED CARE

Chapter 37 - Managed Care

Rule No. 560-X-37-.01. General

(1) The Agency may, at its discretion, and in consultation with local communities, organize and develop area specific systems as part of an overall managed care system.

(a) Flexibility. Since community needs and resources differ from area to area, the Agency will maintain the flexibility to design plans which are consistent with local needs and resources.

(b) Waiver Programs. Plans may be either voluntary or mandatory pursuant to waiver(s) granted by the Centers for Medicare and Medicaid Services (CMS) or the Office of State Health Reform Demonstration. Some plans may start as voluntary and subsequently become mandatory. All required federal waivers must be obtained by Medicaid before any system or contract can become effective.

(c) State Plan Programs. Amendments to the state plan must be approved by CMS before any system or contract can become effective.

(d) Models. It is anticipated that managed care will be accomplished through a combination of primary care case management systems (PCCM), health maintenance organizations (HMO), managed care organizations (MCO) and prepaid Inpatient health plans.

(e) Purpose. The purposes of managed care are to:

(i) Ensure needed access to health care;

(ii) Provide health education;

(iii) Promote continuity of care;

(iv) Strengthen the patient/physician relationship;

and

(v) Achieve cost efficiencies.

(2) (a) Any managed care system established shall comply with the approved Alabama State Plan for Medical Assistance, Alabama Medicaid Administrative Code, ~~T~~the Alabama Medicaid Provider Manual and/or operational protocols, all other guidelines of Medicaid program areas, all state and federal laws and regulations, and any federally approved waivers in effect in the geographical areas of the State in which the system is operational and providing medical services to eligible Medicaid enrollees.

(b) The regulations of CMS at 42 CFR Parts 430, 432, 434, 438, 440, and 447, as promulgated in 67 Federal Register 40988 (June 14, 2002) and 68 Federal Register 3586 (January 24, 2003), and as may be subsequently amended, are adopted by reference. Copies of these regulations may be obtained from the US Government Printing Office, Washington, DC 20402 or at www.gpo.gov.su_docs/aces/aces140.html. Copies are also available from Medicaid at a cost of $7.00.

(3) Any managed care system or provider shall comply with all federal and state laws, rules and regulations relating to discrimination and equal employment opportunity, Titles VI and VII of the Civil Rights Act of 1964, as amended, the Federal Age Discrimination Act, Section 504 of the Rehabilitation Act of 1973, and Americans with Disabilities Act of 1990.

(4) The terminology and definitions in this chapter may be referenced in their entirety in 42 CFR 438.2. An abbreviated list follows:

(a) *Capitation payment* means a payment the state agency makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the state plan.

(b) *Capitated risk contract* means a risk contract that covers comprehensive services, that is, inpatient hospital services and any of the services listed in Rule 560-X-37-.03 (2).

(c) *Federally qualified HMO* means an HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

(d) *Health care professional* means a physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(e) *Health insuring organization (HIO*) means a county operated entity, that in exchange for capitation payments, covers services for recipients through payments to, or arrangements with, providers under a comprehensive risk contract with the state.

(f) *Managed care organization (MCO*) means an entity that has, or is seeking to qualify for, a comprehensive risk contract as defined in 42 CFR, Part 438, and that is a federally qualified HMO that meets the requirements of 42 CFR, Part 489, Subpart I.

(g) *Nonrisk contract* means a contract under which the contractor is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR, Section 447.362.

(h) *Prepaid ambulatory health plan (PAHP*) means an entity that provides medical services to enrollees under contract with the state agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.

(i) *Prepaid inpatient health plan (PIHP*) means an entity that provides medical services to enrollees under contract with the state agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.

(j) *Primary care* means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

(k) *Primary care case management* means a system under which a PCCM contracts with the state to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid recipients.

(l) *Primary care case manager (PCCM*) means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services.

(m) *Primary medical provider (PMP*) means a family practitioner, general practitioner, internist, or pediatrician, an entity that provides or arranges for PMP coverage for services, consultation, or referrals 24 hours a day, seven days a week.

(n) *Risk contract* means a contract under which the contractor assumes risk for the cost of the services covered under the contract; and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

(5) The contract requirements in this chapter may be referenced in their entirety in 42 CFR 438.6. An abbreviated list follows:

(a) The CMS Regional Office must review and approve all MCO, PIHP, and PAHP contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirement in 438.806.

(b) Payments under risk contracts must be based on actuarially sound capitation rates that have been developed in accordance with generally accepted actuarial principles and practices; and are appropriate for the populations to be covered, and the services to be furnished under the contract.

(c) All contracts in this chapter must comply with all applicable federal and state laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

(d) Physician incentive plans (PIP) do not apply to contracts in this chapter.

(e) All MCO and PIHP contracts must provide for compliance with the requirements of 422.128 for maintaining written policies and procedures for advance directives. The entity subject to this requirement must provide adult enrollees with written information on advance directives policies, and include a description of applicable state law.

(f) PCCM contracts must meet the following requirements:

(i) Provide for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions.

(ii) Restrict enrollment to recipients who reside sufficiently near one of the manager's delivery sites to reach that site within a reasonable time using available and affordable modes of transportation.

(iii) Provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.

(iv) Prohibit discrimination in enrollment, disenrollment, and reenrollment, based on the recipient's health status or need for health care services.

(v) Provide that enrollees have the right to disenroll from their PCCM in accordance with 438.56 (c).

(6) The information requirements in this chapter may be referenced in their entirety in 42 CFR 438.10. An abbreviated list follows:

(a) *Enrollee* means a Medicaid recipient who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program.

(b) *Potential enrollee* means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, or PCCM.

(c) Each state enrollment broker must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.

(d) The state must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.

(e) The state must establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the state. *Prevalent* means a non-English language spoken by a significant number of potential enrollees and enrollees in the state.

(f) The state and each managed care entity must make available written information in the prevalent non-English languages.

(g) The state must notify enrollees and potential enrollees and require each managed care entity to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages.

(7) The provider discrimination prohibitions in this chapter may be found in their entirety in 42 CFR 438.12. An abbreviated list follows:

(a) A managed care entity may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his license or certification under applicable state law, solely on the basis of that license or certification. If a managed care entity declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

(b) In all contracts with health care professionals, a managed care entity must comply with the requirements in 438.214.

(8) The enrollment requirements in this chapter may be found in their entirety in 42 CFR 438.50 through 438.66. An abbreviated list follows:

(a) A state plan that requires Medicaid recipients to enroll in managed care entities must comply with the provisions of this section, except when the state imposes the requirement as part of a demonstration project under section 1115 of the Act; or under a waiver granted under section 1915(b) of the Act.

(b) The state plan must specify the types of entities with which the state contracts; whether the payment method is fee for service or capitated; whether it contracts on a comprehensive risk basis; and the process the state uses to involve the public in both design and initial implementation of the program and the methods it uses to ensure ongoing public involvement once the state plan has been implemented.

(c) The plan must provide assurances that the state meets applicable requirements of section 1903(m) of the Act for MCOs; section 1905(t) of the Act for PCCMs; and section 1932(a)(1)(A) of the Act for the state's option to limit freedom of choice by requirring recipients to receive their benefits through managed care entities.

(d) The state must provide assurances that, in implementing the state plan managed care option, it will not require the following groups to enroll in an MCO or PCCM:

(i) Medicare eligible recipients;

(ii) Indians who are members of federally recognized tribes, except when the MCO or PCCM is the Indian Health Service or an Indian health program operated under a contract, grant, etc., with the Indian Health Service;

(iii) Children under 19 years of age who are eligible for SSI under title XVI; eligible under section 1902(e)(3) of the Act; in foster care or out of home placement; receiving foster care or adoption assistance; or receiving services through a community based care system.

(e) The state must have an enrollment system under which recipients already enrolled in an MCO or PCCM are given priority to continue that enrollment if the MCO or PCCM does not have the capacity accept all those seeking enrollment under the program.

(f) For recipients who do not choose an MCO or PCCM during their enrollment period, the state must have a default enrollment process for assigning those recipients to contracting MCOs and PCCMs.

(g) The process must seek to preserve existing provider-recipient relationships and relationships with providers that have traditionally served Medicaid recipients.

(h) An *existing provider-recipient relationship* is one in which the provider was the main source of Medicaid services for the recipient during the previous year.

(i) A provider is considered to have *traditionally served* Medicaid recipients if it has experience in serving the Medicaid population.

(9) The recipient choice requirements in this chapter may be found in their entirety in 42 CFR 438.52. An abbreviated list follows:

(a) A state that requires Medicaid recipients to enroll in an MCO, PIHP, PAHP or PCCM system must give those recipients a choice of at least two entities.

(b) A state may limit a rural area recipient to a single managed care entity with the exceptions noted in 438.52(b).

(c) A state may limit recipients to a single HIO if the recipient has a choice of at least two primary care providers within the entity.

(d) A state's limitation on an enrollee's freedom to change between primary care providers may be no more restrictive than the limitations on disrollment noted in 438.56.

(10) The disenrollment requirements and limitations in this chapter may be found in their entirety in 42 CFR 438.56. An abbreviated list follows:

(a) The provisions of this section apply to all managed care arrangements whether enrollment is mandatory or voluntary and whether the contract is with an MCO, a PIHP, a PAHP, or a PCCM.

(b) All contracts must specify the reasons for which the entity may request disenrollment of an enrollee.

(c) The entity may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

(d) All contracts must specify the methods by which the entity assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.

(e) All contracts must specify that a recipient may request disenrollment for cause at any time, or without cause at the following times:

(i) During the 90 days following the date of the recipient's initial enrollment with the entity or the date the state sends the recipient notice of the enrollment, whichever is later.

(ii) At least once every 12 months thereafter.

(iii) Upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

(f) Recipients (or their representatives) must submit oral or written requests for disenrollment to the state agency or the managed care entity (if the state permits the entity to process such requests).

(g) The following are cause for disenrollment:

(i) The enrollee moves out of the entity's service area.

(ii) The plan does not, because of moral or religious objections, cover the service the enrollee seeks.

(iii) The enrollee needs related services to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

(iv) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

(h) The state agency must complete the determination on the recipient's (or the entity's) request so that the effective date of disenrollment is no later than the first day of the second month following the month in which the recipient (or the entity) files the request.

(11) The state must have in effect safeguards against conflict of interest on the part of employees and agents of the state who have responsibilities relating to the managed care contracts. Medicaid employees must comply with the state ethics laws including, but not limited to, Code of Alabama (1975), Sections 36-25-5, -7, -8, -11, -12, and -13.

(12) The state must ensure that no payment is made to a provider other than the managed care entity for services available under the contract between the state and the entity. Medicaid ensures compliance with 438.60 through the systematic plan code determination at the detail level of a claim.

(13) The state must arrange for Medicaid services to be provided without delay to any Medicaid enrollee of a managed care entity whose contract is terminated and for any Medicaid enrollee who is disenrolled from an entity for any reason other than ineligibility for Medicaid.

(14) The state must have in effect procedures for monitoring the entity's operations, including at a minimum, operations related to the following:

(a) Recipient enrollment and disenrollment.
(b) Processing of grievances and appeals.
(c) Violations subject to intermediate sanctions.
(d) Violations of the conditions for FFP.
(e) All other conditions of the contract as appropriate.

(15) The enrollee rights in this chapter may be found in their entirety in 42 CFR 438.100. An abbreviated list follows:

(a) The state must ensure that each managed care entity has written policies regarding the enrollee rights specified in 438.100.

(b) Each entity shall comply with any applicable federal and state laws that pertain to enrollee rights and shall ensure that its staff and providers take those rights into account when furnishing services to enrollees.

(c) An enrollee of a managed care entity has the right to:

(i) Receive information in accordance with 438.10.

(ii) Be treated with respect and with due consideration for this or her dignity and privacy.

(iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

(iv) Participate in decisions regarding his or her health care.

(v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

(vi) Request and receive a copy of his or her medical records, and request that they be amended or corrected.

(d) An enrollee of a managed care entity has the right to be furnished health care services in accordance with 438.206 through 438.210.

(e) The state must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the managed care entity and its providers treat the enrollee.

(f) The state must ensure that each entity complies with any other applicable federal and state laws.

(16) The provider-enrollee communications in this chapter may be found in their entirety in 42 CFR 438.102. An abbreviated list follows:

(a) A managed care entity may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is his or her patient, for the following:

(i) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

(ii) Any information the enrollee needs in order to decide among all relevant treatment options.

(iii) The risks, benefits, and consequences of treatment or nontreatment.

(iv) The enrollee's rights to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(17) The marketing activities described in this chapter may be found in their entirety in 42 CFR 438.104. An abbreviated list follows:

(a) *Cold-call marketing* means any unsolicited personal contact by the managed care entity for the purpose of marketing.

(b) *Marketing* means any communication from a managed care entity to a Medicaid recipient who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular entity's Medicaid product, or either to not enroll in, or to disenroll from, another entity's Medicaid product.

(c) Each contract with a managed care entity must provide that the entity does not distribute any marketing materials without first obtaining state approval.

(18) The rules concerning liability for payment may be found in their entirety in 42 CFR 438.106. An abbreviated list follows:

(a) Each managed care entity must provide that its Medicaid enrollees are not held liable for any of the following:

(i) The entity's debts in the event of insolvency.

(ii) Covered services provided to the enrollee for which the state does not pay the entity, or the state or the entity does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement.

(iii) Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the entity provided the services directly.

(19) All contracts must provide that any cost sharing imposed on Medicaid enrollees is in accordance with 447.50 through 447.60.

(20) The rules concerning emergency and poststabilization services may be found in their entirety in 42 CFR 438.114. An abbreviated list follows:

(a) *Emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent

layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(ii) Serious impairment to bodily functions.

(iii) Serious dysfunction of any bodily organ or part.

(b) *Emergency services* means covered inpatient and outpatient services that are as follows:

(i) Furnished by a provider that is qualified to furnish these services.

(ii) Needed to evaluate or stabilize an emergency medical condition.

(c) *Poststabilization care services* means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

(21) The solvency standards in this chapter may be found in their entirety in 42 CFR 438.116. An abbreviated list follows:

(a) Each MCO, PIHP, and PAHP that is not a federally qualified HMO must provide assurances to the state showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the managed care entity's debts if the entity becomes insolvent.

(b) Federally qualified HMOs are exempt from this requirement.

(22) The quality assessment and performance improvement standards in this chapter may be found in their entirety in 42 CFR, 438.200. An abbreviated list follows:

(a) The state must have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

(b) The state must obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it as final.

(c) The state must ensure that MCOs, PIHPs, and PAHPs comply with standards established by the state consistent with the regulations found in 42 CFR, Part 438.

(d) The state must conduct periodic reviews to evaluate the effectiveness of the strategy and update the strategy periodically as needed.

(e) The state must submit to CMS a copy of the initial strategy and the revised strategy whenever significant changes are made, as well as regular reports on the effectiveness of the strategy.

(23) The elements of state quality strategies in this chapter may be found in their entirety in 42 CFR 438.204. An abbreviated list follows:

(a) The contracts with MCOs and PIHPs must contain procedures that:

(i) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.

(ii) Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. The state must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.

(iii) Regularly monitor and evaluate the MCO and PIHP compliance with the standards.

(iv) Arrange for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered.

(24) The rules concerning availability of services in this chapter may be found in their entirety in 42 CFR 438.206. An abbreviated list follows:

(a) The state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs and PAHPs.

(b) The state must ensure through its contracts that each entity, consistent with the entity's scope of contracted services, meets the following requirements:

(i) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.

(ii) Considers the anticipated Medicaid enrollment.

(iii) Considers the expected utilization of services, taking into account the characteristics and health care needs of specific Medicaid populations represented in the particular entity.

(iv) Considers the numbers and types of providers required to furnish the contracted Medicaid services.

(v) Considers the numbers of network providers who are not accepting new Medicaid patients.

(vi) Considers the geographic location of providers and enrollees.

(c) Each entity must do the following:

(i) Meet and require its providers to meet state standards for timely access to care and services, taking into account the urgency of the need for services.

(ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service.

(iii) Make services included in the contract available 24 hours a day, seven days a week when medically necessary.

(iv) Establish mechanisms to ensure compliance by providers.

(v) Monitor providers regularly to determine compliance.

(vi) Take corrective action if there is a failure to comply.

(25) The assurances of adequate capacity and services in this chapter may be found in their entirety in 42 CFR 438.207 An abbreviated list follows:

(a) The state must ensure, through its contracts, that each entity gives assurances to the state and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the state's standards for access to care.

(b) Each entity must submit documentation to the state, in a format specified by the state, to demonstrate that it complies with the following requirements:

(i) Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area.

(ii) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

(c) Each entity must submit the documentation to the state at the time it enters into a contract with Medicaid and at any time there has been a significant change in the entity's operations that would affect capacity and services.

(26) The requirements for coordination and continuity of care in this chapter may be found in their entirety in 42 CFR 438.208. An abbreviated list follows:

(a) Each managed care entity must implement procedures to deliver primary care and to coordinate health care service for all the entity's enrollees. These procedures must meet state requirements and must do the following:

(i) Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.

(ii) Coordinate the services the entity furnishes to the enrollee with the services the enrollee receives from any other entity.

(iii) Share with other entities serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.

(iv) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with state and federal requirements to the extent that they are applicable.

(27) The requirements for coverage and authorization of services in this chapter may be found in their entirety in 42 CFR 438.210. An abbreviated list follows:

(a) Each contract with a managed care entity must identify, define, and specify the amount, duration, and scope of each service that the entity is required to offer.

(b) The services identified in each entity's contract must be furnished in the same manner that recipients receive under fee-for-service Medicaid.

(c) Each contract must ensure that the services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services were furnished.

(d) The entity may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of a diagnosis, type of illness, or condition of the beneficiary.

(28) The requirements for provider selection in this chapter may be found in their entirety in 42 CFR, 432.214. An abbreviated list follows:

(a) Medicaid must ensure through its contracts that each entity implements written policies and procedures for selection and retention of providers.

(b) Medicaid must establish a uniform credentialing and recredentialing policy that each entity must follow.

(c) Each entity must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the entity.

(d) The entity's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

(e) The managed care entities may not employ or contract with providers excluded from participation in federal health care programs.

(f) Each entity must comply with any additional requirements established by Medicaid.

(29) The enrollee information requirements that the state must meet under the regulations in 438.10 constitute part of Medicaid's quality strategy at 438.204.

(30) Medicaid must ensure, through its contracts, for medical records and any other health and enrollment information that identifies any particular enrollee, each entity uses and discloses such information in accordance with applicable state and federal laws.

(31) Medicaid must ensure that each entity's contract complies with the enrollment and disenrollment requirements and limitations set forth in 438.56.

(32) Medicaid must ensure, through its contracts, that each entity has in effect a grievance system that meets the requirements of 438.400 through 438.424.

(33) The requirements concerning subcontractual relationships and delegation in this chapter may be found in their entirety in 42 CFR 438.230. An abbreviated list follows:

(a) Medicaid must ensure, through its contracts, that each entity oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor.

(b) Before any delegation, each entity must evaluate the prospective subcontractor's ability to perform the activities to be delegated.

(c) A written agreement between the entity and the subcontractor must specify the activities and report responsibilities delegated to the subcontractor; and must provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

(34) The requirements for practice guidelines in this chapter may be found in their entirety in 42 CFR 438.236. An abbreviated list follows:

(a) Medicaid must ensure, through its contracts, that each entity adopts practice guidelines that meet the following requirements:

(i) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(ii) Consider the needs of the entity's enrollees.

(iii) Are adopted in consultation with contracting health care professionals.

(iv) Are reviewed and updated periodically as appropriate.

(35) The requirements for quality assessment and performance improvement programs in this chapter may be found in their entirety in 42 CFR 438.240. An abbreviated list follows:

(a) Medicaid must require, through its contracts, that each entity has an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.

(b) At a minimum, Medicaid must require that each entity comply with the following requirements:

(i) Conduct performance improvement projects that are designed to achieve significant improvement in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

(ii) Submit performance measurement data to Medicaid annually.

(iii) Have in effect mechanisms to detect both underutilization and overutilization of services.

(iv) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

(36) The requirements for health information systems in this chapter may be found in their entirety in 42 CFR 438.242. An abbreviated list follows:

(a) Medicaid must ensure, through its contracts, that each entity maintains a health information system that collects, analyzes, integrates, and reports data.

(b) The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

(c) The entity must make all collected data available to Medicaid and upon request to CMS.

(37) The requirements for grievance systems in this chapter may be found in their entirety in 42 CFR 438.400. An abbreviated list follows:

(a) The Medicaid state plan provides an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(b) The Medicaid state plan provides for methods of administration that are necessary for the proper and efficient operation of the plan.

(c) Medicaid must require, through its contracts, that entities establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(d) In the case of an entity, *action* means:

(i) The denial or limited authorization of a requested service

(ii) The reduction, suspension, or termination of a previously authorized service.

(iii) The denial, in whole or in part, of payment for a service.

(iv) The failure to provide services in a timely manner as defined by the state.

(v) The failure of the entity to act within the timeframes provided in 438.408.

(e) *Appeal* means a request for review of an action, as "action" is defined above.

(f) *Grievance* means an expression of dissatisfaction about any matter other than an action, as "action" is defined above.

(38) The grievance system requirements in this chapter may be found in their entirety in 42 CFR 438.402. An abbreviated list follows:

(a) Each entity must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the state's fair hearing system.

(b) An enrollee, or a provider acting on behalf of the enrollee, may file an appeal, a grievance, or request a fair hearing.

(c) Medicaid will specify a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the entity's notice of action.

(39) The requirements for notice of action in this chapter may be found in their entirety in 42 CFR 438.404. An abbreviated list follows:

(a) The notice must be in writing and must meet the language and format requirements of 438.10(c) and (d) to ensure ease of understanding

(b) The notice must explain the following:

(i) The action the entity or its contractor has taken or intends to take.

(ii) The reasons for the action.

(iii) The enrollee's or the provider's right to file an appeal.

(iv) The enrollee's right to request a state fair hearing.

(v) The procedures for exercising the rights specified in this section.

(vi) The circumstances under which expedited resolution is available and how to request it.

(vii) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(40) The requirements for the handling of grievances and appeals in this chapter may be found in their entirety in 42 CFR 438.406. An abbreviated list follows:

(a) In handling grievances and appeals, each entity must meet the following requirements:

(i) Give enrollees any reasonable assistance in completing forms and taking other procedural steps.

(ii) Acknowledge receipt of each grievance and appeal.

(iii) Ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making; or are health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease.

(41) The requirements for resolution and notification of grievances and appeals may be found in their entirety in 42 CFR 438.408. An abbreviated list follows:

(a) The managed care entity must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within the timeframes established by the state.

(b) The entity may extend the timeframes by up to 14 days if the enrollee requests the extension; or the entity demonstrates that there is need for additional information and how the delay is in the enrollee's interest.

(42) The requirements for expedited resolution of appeals in this chapter may be found in their entirety in 42 CFR 438.410. Each entity must establish and maintain an expedited review process for appeals, when the entity determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health.

(43) The managed care entity must provide the information specified at 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

(44) Medicaid must require, through its contracts, each entity to maintain records of grievances and appeals and must review the information as part of the state quality strategy.

(45) The requirements concerning continuation of benefits (while an appeal or fair hearing is pending) in this chapter may be found in their entirety in 42 CFR 438.420. The managed care entity must continue the enrollee's benefits if:

(a) The enrollee or the provider files the appeal timely.

(b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

(c) The services were ordered by an authorized provider.

(d) The original period covered by the original authorization has not expired.

(e) The enrollee requests extension of benefits.

(46) The requirements for effectuation of reversed appeal resolutions may be found in their entirety in 42 CFR 438.424.

(47) The requirements concerning fair hearings in this chapter may be found in their entirety in 42 CFR 431.200, et seq., and Chapter Three of this code. The Medicaid state plan must ensure that the regulations in these sections apply when a fair hearing is requested by an enrollee.

(48) The requirements concerning certifications and program integrity in this chapter may be found in their entirety in 42 CFR 438.600 through 438.610. An abbreviated list follows:

(a) When state payments to a managed care entity are based on data submitted by the entity, the state must require certification of the data as provided in 438.606.

(b) The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the state.

(c) The data submitted to the state must be certified by either the entity's chief executive officer, chief financial officer, or an individual who has been delegated the authority to sign for these officers.

(d) The certification must attest to the accuracy, completeness, and truthfulness of the submitted data.

(e) The entity must have procedures that are designed to guard against fraud and abuse.

(f) The entity must have written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable state and federal standards.

(g) The entity may not knowingly have a relationship with an individual who is debarred, suspended, or otherwise excluded from participation in state or federal health care programs.

(49) The requirements concerning sanctions in this chapter may be found in their entirety in 42 CFR 438.700 through 438.730. An abbreviated list follows:

(a) Medicaid must establish, through its contracts with managed care entities, intermediate provider sanctions that may be imposed upon the state's findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(b) Medicaid may impose sanctions that include the following:

(i) Civil money penalties.

(ii) Appointment of temporary management for the entity.

(iii) Granting enrollees the right to terminate enrollment without cause.

(iv) Suspension of all new enrollment after the effective date of the sanction.

(v) Suspension of payment for recipients enrolled after the effective date of the sanction.

(50) The requirements concerning federal financial participation (FFP) in this chapter may be found in their entirety in 42 CFR 438.602 through 438.812. An abbreviated list follows:

(a) FFP is not available in an MCO contract that does not have prior approval from CMS.

(b) Under a risk contract, the total amount Medicaid pays for carrying out the contract provisions is a medical assistance cost.

(c) Under a nonrisk contract, the amount Medicaid pays for the furnishing of medical services to eligible recipients is a medical assistance cost; and the amount paid for the contractor's performance of other functions is an administrative cost.

(51) The requirements for timely processing of claims and cost-sharing in this chapter may be found in their entirety in 42 CFR 447.45 through 447.60. An abbreviated list follows:

(a) A contract with a managed care entity must provide that the entity will meet the requirements of 447.45 and abide by those specifications.

(b) The managed care entity and its providers may, by mutual agreement, establish an alternative payment schedule, which must be stipulated in their contract.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: Alabama State Plan for Medical Assistance (hereinafter State Plan), Section 2.1(c), Attachment 2.1-A; Social Security Act, Title XI and Title XIX, Section 1903(m) (2) (B); 42 C.F.R Section 434.26, Section 434.6; Part 438; Civil Rights Act of 1964, Titles VI and VII, as amended. The Federal Age Discrimination Act. Rehabilitation Act of 1973. The Americans with Disabilities Act of 1990.
History: Effective date July 12, 1996. Amended December 14, 2001. **Amended**: Filed March 20, 2003; effective June 16, 2003.

Rule No. 560-X-37-.02 Primary Care Case Management (PCCM)

(1) Under this model of managed care, each patient/recipient is assigned to a primary medical provider (PMP) who in most cases is a physician who is responsible for managing the recipient's health care needs. This management function neither reduces nor expands the scope of covered services.

(a) PCCM services means case management related services that include location, coordination, and monitoring of primary health care services; and are provided under a contract between Medicaid and one of the providers listed in (2) below.

(b) PCCM services may be offered by the state as a voluntary option under the Medicaid state plan; or on a mandatory basis under a 1915(b) waiver.

(2) Primary Medical Providers (PMP)

(a) Physician PMPs are generally family practitioners, general practitioners, internists or pediatricians. If a patient's condition warrants, PMPs of another specialty may be assigned if he/she is willing to meet all contractual requirements. Patients may be assigned to the individual physician or a group of physicians.

(b) Clinics - In cases of Federally Qualified Health Centers (FQHCs) and Provider Based Rural Health Clinics (PBRHCs) and Independent Rural Health Clinics (IRHCs) patients will be assigned to the clinic.

(3) The Patient 1st PMP agrees to do the following:

(a) Accept enrollees as a primary medical provider in the Patient 1st Program for the purpose of providing care to enrollees and managing their health care needs.

(b) Provide Primary Care and patient coordination services to each enrollee in accordance with the provisions of the Patient 1st agreement and the policies set forth in the Alabama Medicaid Administrative Code, Medicaid provider manuals and Medicaid bulletins and as defined by Patient 1st Policy.

(c) Provide or arrange for Primary Care coverage for services, consultation, management or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week as defined by Patient 1st Policy.

(d) Provide EPSDT services as defined by general Medicaid and Patient 1st Policy.

(e) Establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of enrollees as defined by Patient 1st Policy.

(f) Maintain a unified patient medical record for each enrollee following the medical record documentation guidelines as defined by Patient 1st Policy.

(g) Promptly arrange referrals for medically necessary health care services that are not provided directly, document referral for specialty care in the medical record and provide the authorization number to the referred provider.

(h) Transfer the Patient 1st enrollee's medical record to the receiving provider upon the change of primary medical provider at the request of the new primary care provider and as authorized by the enrollee within 30 days of the date of the request. Enrollees can not be charged for copies.

(i) Authorize care for the enrollee or see the enrollee based on the standards of appointment availability as defined by Patient 1st Policy.

(j) Refer for a second opinion as defined by Patient 1st Policy.

(k) Review and use all enrollee utilization and cost reports provided by the Patient 1st Program for the purpose of practice level utilization management and advise the Agency of errors, omissions, or discrepancies. Review and use the monthly enrollment report as required by Patient 1st Policy.

(l) Participate with Agency utilization management, quality assessment, complaint and grievance, and administrative programs.

(m) Provide the Agency, its duly authorized representatives and appropriate federal Agency representatives unlimited access (including on site inspections and review) to all records relating to the provision of services under this agreement as required by Medicaid policy and 42 C.F.R. 431.107.

(n) Maintain reasonable standards of professional conduct and provide care in conformity with generally accepted medical practice following national and regional clinical practice guidelines or guidelines approved by the Patient 1st Advisory Group.

(o) Notify the Agency of any and all changes to information provided on the initial application for participation. If such changes are not made within 30 days of change , then future participation may be limited.

(p) Give written notice of termination of this agreement, within 15 days after receipt of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis, by the PMP.

(q) Refrain from discriminating against individuals eligible to enroll on the basis of health status or the need for health care services.

(r) Refrain from discriminating against individuals eligible to enroll on the basis of race, color, or national origin and will refrain from using any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

(s) Comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education of Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

(t) Make oral interpretation services available free of charge to each potential enrollee and enrollee. This requirement applies to all non-English languages.

(u) Receive prior approval from the Agency of any Patient 1st specific materials prior to distribution. Materials shall not make any assertion or statement (whether written or oral) that the recipient must enroll with the PMP in order to obtain benefits or in order not to lose benefits. Materials shall not make any assertion or statement that the PMP is endorsed by CMS, the Federal or State government or similar entity.

(v) Refrain from door-to-door, telephonic or other 'cold-call' marketing or engaging in marketing activities that could mislead, confuse, or defraud Medicaid Recipients, or misrepresent the PMP, its marketing representatives, or the Agency.

(w) Refrain from knowingly engaging in a relationship with the following:

- an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
- an individual who is an affiliate, as defined in the Federal Acquisition Regulation.

Note: The relationship is described as follows:

- As a director, officer, partner of the PMP,
- A person with beneficial ownership of more than five percent (5%) or more of the PMP 's equity; or,
- A person with an employment, consulting or other arrangement with the PMP for the provision of items and services that are significant and material to the PMP's contractual obligation with the Agency.

(x) Retain records in accordance with requirements of 45 C.F.R. 74 (3 years after the final payment is made and all pending matters closed, plus additional time if an audit, litigation, or other legal action involving the records is started before the original 3 year period ends.)

(y) Provide the Agency within 30 days notice of PMP disenrollment or change in practice site. This will allow for an orderly reassignment of enrollees. Failure to provide 30 days notice may preclude future participation and/or result in recoupment of case management fees.

(4) Recipients can choose or will be assigned to a PMP prior to the lock-in date to the PCCM program. Recipients have the ability to change PMPs on a monthly basis. Changes must be requested prior to the 20th of the month for the change to be effective the first of the following month.

(5) In order to participate in the PCCM system, a provider must sign an agreement with Medicaid that will detail the requirements of the PCCM system. PMPs will be paid a monthly medical case management fee for primary care case management

services in an amount determined by the Agency. The fee will be based on the number of recipients enrolled for the provider on the first day of each month.

(6) The Case Management fee will be automatically paid to the PMP on the 1st checkwrite of each month. The monthly case management fee will be determined by the components of care to which the PMP has agreed. Case Management fees will be adjusted quarterly. The monthly enrollment summary report will indicate the individual amount of case management fee being paid for that month. As additional case management components are offered, PMPs will be given the opportunity to decide participation. Case management fess are not subject to third party liability requirements as specified in 42 CFR 434.6(a)(9). All direct services are paid fee-for-service through medical claims processing procedures based on the regular Medicaid fee schedule. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) will not receive the case management fee each month.

(7) PMPs are limited to 1200 recipients unless additional numbers are approved by Medicaid. The Agency may increase the number of recipients based on historical caseload; documentation of a predominately Medicaid practice and/or employment of midlevel practitioners.

(8) The failure of a PMP to comply with the terms of this agreement or other provisions of the Medicaid Program governed under Social Security Act Sections 1932, 1903(m) and 1905(t) may result in the following sanctions by the Agency:

(a) Limiting member enrollment with the PMP.

(b) Withholding all or part of the PMP's monthly Patient 1st management/coordination fee.

(c) Referral to the Agency's Program Integrity or Quality Assurance Unit for investigation of potential fraud or quality of care issues.

(d) Referral to Alabama Medical Board or other appropriate licensing board.

(e) Termination of the PMP from the Patient 1st program.

One or more of the above sanctions may be initiated simultaneously at the discretion of the Agency based on the severity of the agreement violation. The Agency makes the determination to initiate sanctions against the PMP. The PMP will be notified of the initiation of a sanction by certified mail. Sanctions may be initiated immediately if the Agency determines that the health or welfare of an enrollee(s) is endangered or within a specified period of time as indicated in the notice. If the PMP disagrees with the sanction determination, he has the right to request an evidentiary hearing as defined by Patient 1st Policy.

Failure of the Agency to impose sanctions for an agreement violation does not prohibit the Agency from exercising its rights to do so for subsequent agreement violations.

Author: Kim Davis-Allen, Director, Medical Services

Statutory Authority: Sections 1915(b)(1)(2)(3), and (4): Sections 1902 (a)(i), (10) and (23) of the Social Security Act, 42 CFR 431.55; 438.2; 440.168.
History: **New Rule:** Filed June 21, 2004; effective September 15, 2004

Rule No. 560-X-37-.03 Prepaid Inpatient Health Plan (PIHP)

(1) A prepaid inpatient health plan (PIHP) is one that provides services to enrolled recipients on a capitated basis but does not qualify as a HMO.

(2) Capitated PIHPs do not need to meet the requirements of §1903(m)(2)(A) of the Social Security Act if services are less than fully comprehensive. Comprehensive services are defined as:

(a) Inpatient hospital services and one or more services or groups of services as follows:

(i) Outpatient hospital services;
(ii) Laboratory and X-ray services;
(iii) Nursing facility (NF) services
(iv) Physician services;
(v) Home health services;
(vi) Rural health clinic services;
(vii) FQHC services;
(viii) Early and periodic screening, diagnostic, and treatment (EPSDT) services; and
(ix) Family planning services.

(b) No inpatient services, but three or more services or groups of services listed in Section (2)(a).

(3) If inpatient services are capitated, but none of the additional services listed in Section (2)(a) above are capitated, the entity may be considered a PIHP.

(4) The Partnership Hospital Program (PHP) is a non-comprehensive Prepaid Inpatient Health Plan (PIHP) operating under the Medicaid state plan. The following further describes the Partnership Hospital Program:

(a) It is an inpatient care program.

(b) It is mandatory for Medicaid recipients, with the exception of recipients with Part A Medicare coverage, SOBRA adults who are enrolled in and receive inpatient care through the Maternity Care program in counties covered by the PHP, and children certified through the Children's Health Insurance Program (CHIP).

(c) It is composed of prepaid inpatient health plans organized by districts in the State of Alabama.

(d) PIHPs operate under the authority granted in the Partnership Hospital Program, a state plan service as approved by CMS.

(e) Medicaid reimburses the prepaid inpatient health plans participating in the Partnership Hospital Program on a per member per month capitation basis.

(f) Prepaid inpatient health plans provide medically necessary inpatient care for covered Medicaid recipients including:

(i) Bed and board

(ii) Nursing services and other related services

(iii) Use of hospital facilities

(iv) Medical social services

(v) Drugs, biologicals, supplies, appliances and equipment

(vi) Certain other diagnostic and therapeutic services, and

(vii) Medical or surgical services provided by certain interns or residents-in-training.

(viii) Excluded are inpatient family planning services and inpatient emergency services.

(g) Prepaid inpatient health plans will assist the participant in gaining access to the health care system and will monitor on an inpatient basis the participant's condition, health care needs, and service delivery.

(h) Prepaid inpatient health plans are responsible for locating, coordinating, and monitoring all inpatient care in acute care hospitals within the state.

(i) Systems required of prepaid health plans, at a minimum, include:

(i) Quality assurance and utilization review systems

(ii) Grievance systems

(iii) Systems to furnish required services, including utilization review

(iv) Systems to prove financial capability

(v) Systems to pay providers of care

(5) The PIHP and Medicaid shall operate a quality assurance (QA) program sufficient to meet those quality review requirements of 42 CFR Part 438, Subpart D, applicable to PIHPs and their providers. The QA Program and any revisions must be approved in writing by Medicaid.

(a) The PIHP shall appoint a QA Committee to implement and supervise the QA Program. This committee shall consist of not less than three healthcare professionals, who may be members of the PIHP board, employees of providers or such other persons in the healthcare field as the PIHP believes will be required to oversee the creation and control of a successful QA Program for the PIHP.

(b) The QA Program shall be a written program specifying:

(i) Utilization control procedures for the on-going evaluation, on a sample basis, of the need for, and the quality and timeliness of care provided to Medicaid eligibles by the PIHP.

(ii) Review procedures by appropriate health professionals of the process, following the provision of health services.

(iii) Procedures for systematic data collection of performance and patient results.

(iv) Procedures for interpretation of these data to the provider.

(v) Procedures for making needed changes.

(c) The QA Committee shall employ a professional staff to obtain and analyze data from Medicaid information systems, the provider hospitals, and such other

sources as the staff deems necessary to carry out the QA Program. All costs of the QA Program shall be paid by the PIHP.

(d) PIHP member hospitals shall conduct continuing internal reviews of their own QA programs. The QA Committee staff shall be given all such assistance and direction by such provider QA programs and shall obtain such reasonable information from such providers as may be necessary to implement the PIHP QA Programs.

(e) The staff shall implement such focused medical reviews of the providers as may be required by Medicaid, required under the QA Program, or believed necessary the staff.

(f) Medicaid staff shall coordinate with the PIHP's QA Committee and staff on QA matters. Medicaid shall make such audits and surveys as it deems reasonably required, but shall do at least one annual medical audit on each PIHP and all of its providers. The PIHP shall provide all information, medical records, or assistance as may be reasonably required for Medicaid to conduct such audits.

(g) Medicaid QA personnel will make periodic on-site visits to review and monitor the QA Program and assess improvements in quality. The PIHP shall make certain all necessary information and records are available at such sites.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Part 434 and 438; State Plan Attachment 4.19-A(f)
History: Rule amended July 12, 1996. Emergency rule effective October 1, 1996. Amended January 14, 1997; January 12, 1998; June 16, 2003.
Amended: Filed April 7, 2004; effective July 16, 2004.

Rule No 560-X-37-.04 Health Maintenance Organizations (HMO)

(1) Health Maintenance Organizations (HMO~~s~~) means any entity or corporation that undertakes to provide or arrange for basic health care services through an organized system which combines the delivery and financing of health care to enrollees. The organization shall provide physician services directly through physician employees or under contractual arrangements with either individual physicians or a group of physicians. The organization shall provide basic health care services directly or under contractual arrangements. When reasonable and appropriate, the organization may provide physician services and basic health care services through other arrangements. The organization may provide, or arrange for, health care services on a prepayment or other financial basis.

(2) Covered services shall be provided to each eligible enrollee and will be reimbursed on a monthly capitation basis.

(3) The HMO is required to obtain a Certificate of Authority to operate as a HMO in the State of Alabama, issued by the Department of Insurance prior to providing services. HMOs must obtain a Certificate of Need (CON) or a letter of non-reviewability from the State Health Planning Agency. When applicable, the HMO may also be required to participate in an Invitation to Bid process as directed by the Medicaid Agency.

(4) The HMO shall make adequate provisions against the risk of insolvency as contained in the Code of Alabama Section 27-21A-12 and as specified in the contract between the HMO and Medicaid. The HMO must ensure that individuals eligible for benefits are never held liable for debts of the plan.

(5) HMOs desiring to participate as a managed care provider should contact the Medical Services Division at Medicaid. HMOs must submit written documentation for approval which includes, but is not limited to, the following:

(a) Description of services to be provided
(b) Marketing Plan and any marketing materials to be used by the plan
(c) Quality Assurance Plan
(d) Enrollment Plan
(e) Education Plan
(f) Copy of Certificate of Authority
(g) Copy of Certificate of Need or letter of non-reviewability
(h) Examples of subcontracts to be utilized by the plan
(i) Proposed enrollment sites
(j) Enrollment area
(k) Grievance procedures

All of the above information must be sent before the review can be completed.

(6) The HMO must ensure contracted health services required by the enrollees are available and accessible through a system that arranges for primary and preventive care provided by and coordinated through a Medicaid enrolled Primary Care Physician (PCP).

(7) Enrollment

(a) In geographical areas that are served by a freedom-of-choice waiver, enrollment in an approved HMO is mandatory for those recipients included in the waiver. Recipients will have the opportunity to voluntarily enroll in an HMO during the open enrollment period, if applicable.

(b) In the event that a recipient who resides in an area that has a freedom-of-choice waiver does not select an HMO, Medicaid will mandatorily assign that recipient to an HMO. In an area where only one HMO is operational under an approved 1115 waiver, the recipient will be required to select a PCP within the HMO's network or be assigned. This will be done according to a formula which meets the needs of the State and the recipients and which is communicated to all health plans in advance. This formula may consist of rotation among the HMOs. Medicaid will notify the HMO of the recipients mandatorily enrolled in their plan via computer compatible media. Recipients that have been mandatorily assigned will also be notified by Medicaid. The effective date of enrollment generally will be the first day of the month following a full calendar month after assignment to an HMO. It is the HMO's responsibility to send to Medicaid

monthly, on computer compatible media, all current enrollees, new enrollees and disenrollments.

(8) Disenrollment

(a) When an enrollee becomes ineligible for Medicaid benefits, is deceased, moves out of the service area, or is changed to a non-covered aid category; the effective date of disenrollment will be the first day of the month following documentation of the change on the Managed Care File.

(b) Any enrollee may elect to disenroll from an HMO, with or without cause, and enroll in another where multiple HMOs participate in the Medicaid program in that area. Recipients are required to submit a written disenrollment request to the HMO with a reason documented in the patient file and on the monthly enrollment information. Disenrollment is effective the first day of the month following a full calendar month after receipt of the disenrollment on the monthly enrollment information.

(c) Unless otherwise specified in an approved waiver, an HMO may disenroll an enrollee whose behavior is disruptive, unruly, abusive, or uncooperative, and not caused by a medical condition, to the extent that his membership in the HMO seriously impairs the HMO's ability to furnish services to that enrollee or other members of the HMO. The HMO is required to provide at least one verbal and one written warning to the enrollee regarding the implication of his actions. No member can be involuntarily disenrolled without the prior written approval of Medicaid.

(d) Unacceptable reasons for an HMO to disenroll an enrollee include pre-existing medical conditions, changes in health status, and periodic missed appointments.

(e) Enrollees may be disenrolled for knowingly committing fraud or permitting abuse of their Medicaid card. Disenrollment of this nature must be promptly reported to Medicaid and must be prior authorized by Medicaid.

(f) The HMO's responsibility for all disenrollments includes supplying disenrollment forms to enrollees desiring to disenroll; ensuring that completed disenrollment forms are maintained in an identifiable enrollee record; ensuring that disenrollees who wish to file a grievance are afforded appropriate notice and opportunity to do so; and ensuring that disenrollees receive written notification of the effective date of and reason for disenrollment. HMOs must submit voluntary disenrollments on the first electronic submission sent to Medicaid after the request is received by the HMO.

(9) Marketing

(a) The Medicaid Agency may elect to enroll recipients through contracted enrollment vendors. If the State chooses to use vendors, HMOs will not be allowed to enroll or recruit patients through marketing representatives.

(b) The HMO shall submit the written marketing plan, procedures, and materials to Medicaid for approval prior to implementation. Enrollment of recipients may not begin until the marketing plan has been approved by Medicaid.

(c) The HMO shall not engage in marketing practices that mislead, confuse, or defraud enrollees, providers, or Medicaid. Mailings, gifts of a material nature, telecommunication and door-to-door marketing are subject to prior approval by the Alabama Medicaid Agency.

(d) Accurate, clear, readable, and concise information shall be made available to eligible recipients and providers in the area serviced by the HMO. Such information shall include, but not be limited to: covered services, location, telephone number, hours of service, enrollment, disenrollment, grievance procedures, and what to do in case of an emergency.

(e) No more than fifty percent (50%) of a marketing representative's total annual compensation, including salary, benefits, bonuses and commission, shall come from commissions.

(10) Grievance Procedures

(a) The HMO shall have a written internal grievance procedure that is approved by Medicaid.

(b) The HMO must have written procedures for prompt and effective resolution of written enrollee grievances.

(c) The HMO must include a description of the grievance system including the right to appeal decisions.

(d) The HMO must maintain records of all oral complaints and written grievances in a log (hard copy or automated).

(e) The HMO must make provisions to accept and resolve grievances filed by individuals other than enrollees.

(11) Quality Assurance

(a) The HMO's Quality Assurance Plan (QAP) must objectively and systematically monitor and evaluate the quality and age appropriateness of care and services through quality of care studies and related activities by following written guidelines predicated on the Quality Assurance Reform Initiative (QARI) which must include:

(i) Goals and objectives;
(ii) Scope;
(iii) Specific activities;
(iv) Continuous activities;
(v) Provider review; and
(vi) Focus on health outcomes.

(b) The Governing Body of the HMO must be responsible for, or designate an accountable entity within the organization to be responsible for, oversight of the QAP.

(c) Each HMO must designate a committee responsible for the performance of QA functions accountable to the Governing Body.

(d) The QAP must objectively and systematically monitor and evaluate the quality and appropriateness of care and service through quality of care studies and related activities.

(e) Each HMO must designate a senior executive to be responsible for QAP implementation and the Medical Director must have subsequent involvement in QAP activities.

(f) The QA Committee must have, as members HMO providers representative of the composition of all providers of service.

(g) The QAP must include provisions for credentialing and recredentialing of health care professionals who are licensed by the State.

(h) HMOs shall allow Medicaid's authorized representative, on an annual basis, to conduct an external independent quality review to analyze the quality of services furnished by the HMO to ensure adequate delivery of care. The results of the review shall be made available to Medicaid, and upon request, to the Secretary of HHS, the Inspector General, and the Comptroller General.

(12) Records

(a) An appropriate record system shall be maintained for all services (including ancillary services) provided to all enrollees. Such records shall be stored in a safe manner to prevent damage and unauthorized use. Records will be reasonably accessible for review.

(b) Entries on medical records shall be authenticated and written legibly in ink or typewritten.

(c) Records must contain all pertinent information relating to the medical management of each enrollee reflecting all aspects of patient care in a detailed, organized and comprehensive manner consistent with medical practice standards.

(d) The HMO shall make available at no cost to Medicaid, the Department of Health and Human Services, and to their designees, any records of the provider and/or subcontractors which relate to the HMO's ability to bear risks for the services performed, amounts paid for benefits, quality review, and any other requested documentation.

(13) Reporting

(a) The HMO shall furnish any information from its records to HHS, the Comptroller General, and/or their agents which may be required to administer the contract. At a minimum, the HMO shall furnish to Medicaid, and to authorized representatives, in a manner and form specified by Medicaid:

(i) Business transactions to include:

a. Any sale, exchange or lease of any property between the HMO and a party in interest;

b. Any lending of money or other extension of credit between the HMO and a party in interest; and

c. Any furnishing for consideration of goods, services (including management services) or facilities between the Plan and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

The information which must be disclosed in the transactions listed above between an HMO and a party in interest includes the name of the party in interest for each transaction, a description of each transaction and the quality of units involved, the accrued dollar value of each transaction during the fiscal year and justification of the reasonableness of each transaction.

(ii) Proposed changes to the marketing plan, procedures or materials;

(iii) Monthly enrollment data to include name, Medicaid number, payee number, and PCP assignment number;

(iv) Utilization data concerning enrollees in the Plan as required by contract;

(v) Summaries of all complaints and all grievances received by the HMO under this contract and actions taken to resolve complaints and grievances quarterly and annually.

(vi) Summaries of amounts recovered from third parties for services rendered to enrollees under the HMO;

(vii) A list of payments made by the HMO during the past month for services purchased through referral and subcontracted providers;

(viii) Encounter data claims submitted directly to Medicaid's fiscal agent for all services paid for or provided by the HMO to enrollees in previous months; and

(x) All other reports as specified and defined in the Managed Care Provider Manual/Operational Protocol and contract.

(b) The HMO will keep and make available to Medicaid, HHS, the Comptroller General, and their agents or authorized representatives, any of the HMO's records which are necessary to fully disclose and substantiate the nature, quality, cost, and extent of items and services provided to enrollees. The HMO shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of five years from the date of the last payment made by Medicaid to the HMO under this contract. However, when audit, litigation, or other action involving records is initiated prior to the end of the five (5) years period, records shall be maintained for a period of five (5) years following the completion of such action and the resolution of all actions which arise from it. Plans shall fully complete and submit to Medicaid quarterly financial statements. Quarterly reports are due for periods ending March 31, June 30, September 30, and December 31 and must be submitted within 45 days of the end of the reporting period or the HMO shall pay a penalty of $100.00 for each day the financial report is delinquent. In addition, the National Association of Insurance Commissioner's Annual Statement Blank, must be fully completed by Contractor annually and submitted to Medicaid. The HMO's annual report must be submitted no later than March 1 or Contractor shall pay to Medicaid a penalty of $100.00 for each day the annual report is delinquent. However, the Commissioner of Medicaid shall have the option to waive the penalty with shown proof by the HMO of good cause for the delay. In addition, the HMO must submit an audited financial statement to Medicaid covering the fiscal year within 90 days of the end of its fiscal year. Contractor shall also promptly submit any and all other financial information requested by Medicaid, HHS, or the Comptroller General.

(14) Payment

(a) Capitation payments to the HMO for all eligible enrollees shall be made monthly.

(b) The HMO shall accept the capitation fees as payment in full for Medicaid benefits provided and shall require its providers to accept payments in full for Medicaid benefits provided.

(c) Neither managed care enrollees nor Medicaid shall be held liable for debts of the HMO in the event of the organization's insolvency.

(d) In-plan covered services must be provided by the HMO chosen by the recipient. These services can be provided directly, through subcontract providers, or by non-contract out-of-plan providers when appropriately referred.

(e) If an enrollee utilizes a non-contract provider for in-plan service, other than emergency services, family planning services, and services provided by a Federally Qualified Health Center (FQHC), the HMO, to the extent allowed by law, may not be held liable for the cost of such utilization unless the HMO referred the enrollee to the non-contract provider or authorized the out-of-plan utilization. Payment by the referring HMO for properly documented claims shall not exceed the maximum fee-for-service rates applicable for the provider for similar services rendered under the Alabama Medicaid Program, unless otherwise agreed upon by the HMO and the non-contract provider. No reimbursement shall be available directly from Medicaid for in-plan services provided by non-contract providers. If there is an FQHC in the geographical area being served by a HMO that contracts with one or more HMO's, an enrollee may elect to join the HMO contracting with the FQHC in order to receive the services offered by the FQHC. If no FQHC in the area agrees to contract with any of the HMOs, the HMOs are obligated to reimburse the FQHC if an enrollee elects to receive services from this entity.

(15) Compliance Review Committee

(a) Alabama Medicaid shall establish a Compliance Review Committee (CRC). The purpose of the CRC is to facilitate resolution of issues related to compliance with the requirements of the contract between the HMO and Medicaid.

(b) Administrative sanctions are reserved for managed care program abuses. Sanctions may be imposed by the Agency for failure to comply with Agency program requirements.

(c) In all cases of HMO abuse, restitution of improper payments or monetary sanctions may be pursued in addition to any administrative sanctions imposed. Administrative sanctions include, but are not limited too, probation. During probation, an HMO may have the number of enrollees it serves limited to a fixed number by the Agency for a set period of time. The HMO will be notified if probation has been authorized for a specific period of time and at the termination of the probation, the HMO will be subject to a follow-up review of its Medicaid Managed Care practice.

(d) The decision as to the sanction(s) to be imposed shall be at the discretion of the Medicaid Commissioner based on the recommendation(s) of the staff of the Managed Care Division, the CRC or other appropriate program review personnel.

(e) The following factors shall be considered in determining the sanctions to be imposed:

(i) Seriousness of the offense(s)

(ii) Extent of violations and history of prior violations

(iii) Prior imposition of sanctions

(iv) Actions taken or recommended by Peer Review Organizations or licensing boards

(v) Effect on health care delivery in the area

When an HMO is reviewed for administrative sanctions, the Agency shall notify the HMO of its final decision and the HMO's entitlement to a hearing in accordance with the Alabama Administrative Procedure Act.

(16) Childrens Health Insurance Program (CHIP)

Children eligible as CHIP children, aged up to 19, who reside in counties in which HMO coverage is available may be included in the program.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: Alabama State Plan for Medical Assistance (hereinafter State Plan), Section 2.1(c), Attachment 2.1-A; Attachment 4.18-A; Social Security Act, Title XI and Title XIX, Section 1903(m); 42 C.F.R. Section 434 et seq.; Civil Rights Act of 1964, Titles VI and VII, as amended. Code of Alabama 1975, Section 22-21-20, et seq., Section 27-21A-1, et seq., and 41-22-1, et seq. The Federal Age Discrimination Act. Rehabilitation Act of 1973. The Americans with Disabilities act of 1990.
History: Effective date is July 12, 1996. Amended January 12, 1998. **Amended**: Filed March 20, 2003; effective June 16, 2003.

Rule No. 560-X-37-.05 Medicare Health Maintenance Organizations (MHMOs) and Competitive Medical Plans (CMPs)

(1) A Medicare Health Maintenance Organizations (MHMO) and Competitive Medical Plans (CMP) are organizations which may contract with the Health Care Financing Administration (HCFA) to enroll Medicare beneficiaries and other individuals and groups to deliver a specified comprehensive range of high quality services efficiently, effectively, and economically to its Medicare enrollees. An HMO or CMP must be organized under the laws of the State and must meet HCFA's qualifying criteria, as specified in 42 C.F.R. §417.410-.418, in order to enter into a contract with HCFA to enroll Medicare beneficiaries.

A Competitive Medical Plan, as defined in 42 C.F.R. §417.407(c), is a legal entity, which provides to its enrollees at least the following services: services performed by physicians; laboratory, x-ray, emergency, and preventive services; out-of-area coverage; and inpatient hospital services. The entity receives compensation by Medicaid for the health care services it provides to enrollees on a periodic, prepaid capitation basis regardless of the frequency, extent, or kind of services provided to any enrollee. The entity provides physician services primarily through physicians who are employees or partners of the entity or physicians or groups of physicians (organized on a group or individual practice basis) under contract with the entity to provide physician services. The entity assumes full financial risk on a prospective basis for provision of health care services, but may obtain insurance or make other arrangements as specified in 42 C.F.R. §417.120 and .407. The entity must provide adequately against the risk of insolvency by meeting the fiscal and administrative requirements of 42 C.F.R. §417.120(a)(1)(i) through (a)(1)(iv) and 417.122(a).

(2) The Alabama Medicaid Agency may reimburse a fixed per member per month (PMPM) capitated payment established by Medicaid to HMOs and CMPs which have an approved Medicare risk contract with the Health Care Financing Administration for beneficiaries who enroll in a Medicare HMO or CMP for which Medicaid is responsible for payment of medical cost sharing. Medicare beneficiaries must receive Part A or Parts A&B coverage to be eligible for this program. This PMPM payment will cover, in full, any premiums or cost sharing required from the Medicare Plan. The PMPM payment will be established based on historical costs and negotiations.

(3) Medicare HMOs and CMPs may enroll with the Medicaid Agency to receive capitated payments for beneficiary premiums and cost sharing by executing a Memorandum Of Understanding with the Medicaid Agency. To enroll the following must be submitted to Medicaid:

(a) A copy of HCFA approval for a Medicare risk contract to enroll Medicare beneficiaries;

(b) A copy of the HMO or the CMP's member services handbook; and

(c) A copy of Certificate of Authority (COA) from the Alabama Insurance Department and appropriate approvals for a material modification to a COA.

(4) All services covered by Medicare shall be covered by the HMO or CMP at no cost to the beneficiary. In addition, the HMO or CMP may offer additional services to the beneficiary (e.g. hearing exams, annual physical exam, eye exams, etc.). The HMO or CMP must notify the Alabama Medicaid Agency prior to adding additional services (identified by procedure code) available to the beneficiary through the Plan. Services covered directly by Medicaid which are not covered by Medicare are not included in the Plan.

(5) The beneficiary will be given freedom of choice in selecting a primary care provider through the Medicare HMO or CMP.

(6) The Medicare HMO or CMP is required to submit a monthly electronic enrollment listing to Medicaid in a format specified by Medicaid.

Authority: State Plan 3.2(a)(10)(E)(i). Social Security Act §1905(p)(1). 42 C.F.R. Section 434.20, Section 434.26, Section 434.23, Section 434.29, Section 434.38, Section 434.6. Effective date is July 12, 1996.

Rule No. 560-X-37-.06 - Family Planning Waiver

(1) The Family Planning Waiver program operates under an approved Section 1115(a) Research and Demonstration Waiver, which extends Medicaid eligibility for family planning services to all women of childbearing age (19 through 44), with incomes at or below 133% of the federal poverty level who would not otherwise qualify for Medicaid. The waiver has been approved for five (5) years and may be renewed with HCFA’s approval.

(2) The program represents a collaborative effort between the Alabama Medicaid Agency and the Alabama Department of Public Health.

(3) The Family Planning Waiver Program is officially known as the "Plan First Program."

(4) Enrolled Medicaid providers are eligible to provide family planning services but must also enroll as a network provider by completing a Plan First agreement. Upon receipt of the signed agreement, Medicaid's fiscal agent will add the Plan First provider specialty code to the provider's existing record. Those providers that only do tubal ligations do not have to enroll as a Plan First provider nor do anesthesia providers for these procedures. There are no changes to current provider eligibility policies due to this waiver.

(5) The following are the eligible groups for the Family Planning Waiver:

(a) Women age 19 through 44 who have SOBRA eligible children will become automatically eligible for family planning without a separate eligibility determination. Women who are not citizens and are payees of SOBRA Medicaid children will be sent a letter along with an application telling them how to apply for the Plan First Program.

(b) SOBRA poverty level pregnant women age 19 through 44 will receive automatic eligibility for family planning services at the expiration of their 60 days postpartum without separate eligibility determination.

(c) Other women age 19 through 44 who are not pregnant and are not applying for a child may apply for family planning services using a simplified shortened application.

(d) SOBRA females who are turning age 19 and would ordinarily be terminated from Medicaid.

Newly awarded family planning recipients will receive a Medicaid plastic card based on the same criteria as other Medicaid recipients. Providers will be informed at the time of eligibility verification that services are limited to family planning only. If a recipient has received a plastic card in the recent past, another card will be sent only upon request.

(6) In order to be eligible for Family Planning Services a woman must:

(a) Furnish a Social Security number or proof they have applied for one

(b) Be a female resident of Alabama age 19 through 44

(c) Meet citizenship and alienage requirements

(d) Have family income at or below 133% of the federal poverty level

(e) Cooperate in establishing third party medical benefits, and apply for all benefits to which she may be entitled

(7) Once determined eligible, a woman will remain eligible for benefits until the termination of the waiver unless she disenrolls or is terminated from the waiver for one of the following reasons:

(a) The recipient's gross countable family income exceeds 133% of the federal poverty level

(b) The recipient does not reside in Alabama

(c) The recipient is deceased

(d) The recipient has received a sterilization procedure

(e) The recipient requests her family planning benefits be terminated

(f) The recipient is outside the family planning age limit of 19 through 44

(g) The recipient is eligible for Medicare benefits

(h) The recipient becomes eligible for another Medicaid program

(i) The recipient fails to cooperate with the Medicaid Agency in the eligibility process, receipt of services or Medicaid Quality Control Review

(j) The recipient is determined ineligible due to fraud, misrepresentation of facts, or incorrect information

(8) Medical services covered for the extended eligibles are limited to birth control services and supplies only. This includes:

(a) All currently covered family planning methods

(b) Outpatient tubal ligation

(c) Doctor/clinic visits (for family planning only)

(d) HIV pre and post test counseling visits

(9) Eligible participants have freedom of choice in the selection of an enrolled network provider. Oral contraceptives must be received from an in-network provider, not from a pharmacy. Network providers may dispense only those oral contraceptives that are on the Alabama Department of Public Health's formulary. Requests from providers for oral contraceptives not on the Health Department's formulary will be reviewed and a decision will be made based on medical necessity of an alternate oral contraceptive.

(10) Oral contraceptives that are dispensed by network providers must be ordered from the Alabama Department of Public Health and must be dispensed only to waiver participants. Stock for waiver participants should be maintained separately from sample stock. Orders should be placed using the "Oral Contraceptives Order Form" provided to network providers and orders should be placed for a three (3) month period and re-ordered when the provider is down to a 30-day supply. Orders will be processed by the Alabama Department of Public Health within five (5) working days of receipt of order form. Order forms will be accepted by general mail or fax.

(11) Under this waiver, Medicaid also reimburses for care coordination activities provided by licensed social workers or registered nurses associated with the Alabama Department of Public Health who have received training on the Family Planning Program. Services are available to all women, regardless of the care site. Care coordination will be reimbursed on a per hour basis in 5 minute increments. Enrolled providers must refer participants to the Health Department to initiate care coordination.

(12) Family Planning Care Coordination will only be available for women eligible through the Family Planning Waiver. Recipients eligible for other Medicaid eligibility programs will be eligible for the regular benefit packages established for those programs and will not be eligible for the enhanced family planning care coordination services.

(13) The Family Planning Waiver program operates under approved Terms and Conditions as specified in the waiver and the Operational Protocol Manual.

Author: Kim Davis-Allen, Director, Medical Services Division.
Statutory Authority: Section 1115(a): Sections 1902(a) (10) (b), (e) (5) and (6) of the Social Security Act.
History: New Emergency Rule filed: August 28, 2000; effective October 1, 2000. Amended: Filed September 21, 2000, effective December 11, 2000. Amended: Filed September 21, 2001, effective December 14, 2001.